

		FOR OFF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040386

Facility Name: PLAZA TERRACE

Address: 3249 WEST 147TH STREET MIDLOTHIAN 60445
Number City Zip Code

County: COOK

Telephone Number: (847) 470-0000 Fax # (847) 967-5462

IDPA ID Number: 36-3874863001

Date of Initial License for Current Owners: 04/01/93

Type of Ownership:

<input type="checkbox"/>	VOLUNTARY,NON-PROFIT	<input checked="" type="checkbox"/>	PROPRIETARY	<input type="checkbox"/>	GOVERNMENTAL
<input type="checkbox"/>	Charitable Corp.	<input type="checkbox"/>	Individual	<input type="checkbox"/>	State
<input type="checkbox"/>	Trust	<input type="checkbox"/>	Partnership	<input type="checkbox"/>	County
IRS Exemption Code		<input type="checkbox"/>	Corporation	<input type="checkbox"/>	Other
		<input checked="" type="checkbox"/>	"Sub-S" Corp.		
		<input type="checkbox"/>	Limited Liability Co.		
		<input type="checkbox"/>	Trust		
		<input type="checkbox"/>	Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA Telephone Number: (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)		(Date)
	(Type or Print Name)	ELI ATKIN	
	(Title)	MANAGER	
Paid Preparer	(Signed)	(SEE ATTACHED ACCOUNTANTS' REPORT)	(Date)
	(Print Name and Title)	BOB KAGDA PARTNER	
	(Firm Name & Address)	KRUPNICK, BOKOR, KAGDA & BROOKS, LTD 3750 W DEVON, LINCOLNWOOD, IL 60712-1124	
	(Telephone)	(847) 675-3585	Fax # (847) 675-5777
	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001		
	Phone # (217) 782-1630		

Facility Name & ID Number PLAZA TERRACE

0040386 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>48</u>	Skilled (SNF)	<u>48</u>	<u>17,520</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>44</u>	Intermediate (ICF)	<u>44</u>	<u>16,060</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>92</u>	TOTALS	<u>92</u>	<u>33,580</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>2,330</u>	<u>125</u>	<u>2,743</u>	<u>5,198</u>	8
9	SNF/PED					9
10	ICF	<u>20,970</u>	<u>1,127</u>	<u>1,201</u>	<u>23,298</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>23,300</u>	<u>1,252</u>	<u>3,944</u>	<u>28,496</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.86%

D. How many bed-hold days during this year were paid by the Department? 26 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 04/01/93

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 04/01/93 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 48 and days of care provided 2,743

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **PLAZA TERRACE** # **0040386** Report Period Beginning: **01/01/2005** Ending: **12/31/2005**

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	162,021	9,842	1,464	173,327		173,327		173,327			1
2	Food Purchase		149,154		149,154	(8,924)	140,230	(718)	139,512			2
3	Housekeeping	76,503	11,101		87,604		87,604		87,604			3
4	Laundry	40,245	14,154		54,399		54,399		54,399			4
5	Heat and Other Utilities			64,923	64,923		64,923		64,923			5
6	Maintenance	46,108	60,544	20,418	127,070		127,070		127,070			6
7	Other (specify):*			19,536	19,536		19,536		19,536			7
8	TOTAL General Services	324,877	244,795	106,341	676,013	(8,924)	667,089	(718)	666,371			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,024,237	80,349	8,534	1,113,120		1,113,120		1,113,120			10
10a	Therapy	29,154	967		30,121		30,121		30,121			10a
11	Activities	54,540	13,251		67,791		67,791		67,791			11
12	Social Services											12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,107,931	94,567	8,534	1,211,032		1,211,032		1,211,032			16
	C. General Administration											
17	Administrative	44,276		258,778	303,054		303,054	47,927	350,981			17
18	Directors Fees											18
19	Professional Services			67,497	67,497		67,497	(1,955)	65,542			19
20	Dues, Fees, Subscriptions & Promotions			17,217	17,217		17,217	(12,571)	4,646			20
21	Clerical & General Office Expenses	46,166	16,637	158,835	221,638		221,638	(97,003)	124,635			21
22	Employee Benefits & Payroll Taxes			250,269	250,269	8,924	259,193		259,193			22
23	Inservice Training & Education			6,122	6,122		6,122		6,122			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			18,284	18,284		18,284		18,284			25
26	Insurance-Prop.Liab.Malpractice			70,620	70,620		70,620		70,620			26
27	Other (specify):*			6,382	6,382		6,382	18,735	25,117			27
28	TOTAL General Administration	90,442	16,637	854,004	961,083	8,924	970,007	(44,867)	925,140			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,523,250	355,999	968,879	2,848,128		2,848,128	(45,585)	2,802,543			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
1	DIETARY		
	DIETITIAN CONSULTANT	XVIII B 35-2	0
	REPAIRS & MAINTENANCE		1,464
			0
			1,464
3	HOUSEKEEPING		
			0
			0
			0
4	LAUNDRY		
	EQUIPMENT REPAIRS & MAINTENANCE		0
			0
			0
5	HEAT & OTHER UTILITIES		
	GAS HEAT		26,580
	ELECTRICITY		29,102
	WATER		9,241
	CABLE TV - LOBBY		0
			0
			64,923
6	MAINTENANCE		
	GROUNDS MAINTENANCE		9,510
	PAINTING & DECORATING		0
	BUILDING REPAIRS		0
	MAINTENANCE TRAVEL		0
	EQUIPMENT MAINTENANCE & REPAIR		1,694
	ELEVATOR MAINTENANCE & REPAIR		0
	OUTSIDE LABOR		0
	EXTERMINATING SERVICE		2,054
	FIRE SERVICE		7,160
			0
			0
			0
			20,418
7	OTHER		
	SCAVENGER		19,536
	SECURITY SERVICE		0
			19,536
9	MEDICAL DIRECTOR		
	MEDICAL DIRECTOR FEES	XVIII B 36-2	0
			0

LINE		SCHED REF	TOTAL
10	NURSING		
	CONTRACT NURSING	XVIII C 53-2	
	LABORATORY & XRAY EXPENSE		6,939
	PURCHASED SERVICES		0
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0
	PHARMACY CONSULTANT	XVIII B 39-2	1,595
	UTILIZATION REVIEW FEES	XVIII B __-2	0
	PHYSICIANS	XVIII B __-2	0
	PSYCHIATRIC	XVIII B __-2	0
	RN CONSULTANT	XVIII B 38-2	0
			0
			0
			8,534
10a	THERAPY		
	PHYSICAL THERAPY SERVICES		
	SPEECH THERAPY SERVICES		0
	OCCUPATIONAL THERAPY SERVICES		0
	REHABILITATION CONSULTANT	XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0
			0
11	ACTIVITIES		
	CABLE TV - PATIENT ROOMS		0
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0
			0
			0
12	SOCIAL SERVICES		
	SOCIAL REHABILITATION SERVICES		0
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0
	SOCIAL WORKER	XVIII B 45-2	0
			0
			0
13	NURSE AIDE TRAINING		
	NURSE AIDE TRAINING COSTS	XIII	0
			0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION		
	PATIENT TRANSPORTATION	0	0
17	ADMINISTRATIVE		
	MANAGEMENT FEES	XIX B 258,778	258,778
18	DIRECTORS FEES	0	0
19	PROFESSIONAL SERVICES		
	DATA PROCESSING	XIX C 7,522	
	ADMINISTRATIVE CONSULTANTS	XIX C 0	
	PROFESSIONAL FEES	XIX C 59,975	
		0	67,497
20	FEES,SUBSCRIPTIONS,PROMOTIONS		
	ENTERTAINMENT & MARKETING	VI 19 XIX F 0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F 12,274	
	EMPLOYEE WANT ADS	XIX F 0	
	CONTRIBUTIONS	VI 20 XIX F 0	
	DUES & SUBSCRIPTIONS	XIX F 1,729	
	LICENSES & PERMITS	XIX F 941	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F 0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F 297	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F 0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F 0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F 1,976	17,217
21	CLERICAL & GENERAL OFFICE EXPENSES		
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	53,012	
	EQUIPMENT REPAIR & MAINTENANCE	1,220	
	OUTSIDE CLERICAL SERVICES	76,644	
	PENALTIES / OVERDRAFT CHARGES	VI 18 5,622	
	HOME OFFICE EXPENSE	0	
	THEFT & DAMAGE LOSS	0	
	TELEPHONE	22,337	
	MESSENGER SERVICE	0	
		0	158,835

LINE		SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	FICA TAXES	XIX D 116,234	
	UNEMPLOYMENT COMPENSATION	XIX D 45,995	
	WORKERS COMPENSATION INSURANCE	XIX D 38,918	
	HOSPITALIZATION INSURANCE	XIX D 34,444	
	EMPLOYEE BENEFITS - OTHER	XIX D 14,678	
	EMPLOYEE PHYSICAL EXAMS	XIX D 0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D 0	
	PENSION/PROFIT SHARING PLANS	XIX D 0	
	CHICAGO HEAD TAX	XIX D 0	250,269
23	INSERVICE TRAINING & EDUCATION		
	EDUCATION & SEMINARS	6,122	6,122
24	TRAVEL & SEMINARS		
	EDUCATION & SEMINARS	XIX G 0	
	TRAVEL	XIX G 0	
		0	
		0	0
25	ADMIN. STAFF TRANSPORTATION		
	TRANSPORTATION - STAFF	18,284	18,284
26	INSURANCE - PROP. LIAB & MALPRACTICE		
	GENERAL INSURANCE	70,620	70,620
27	OTHER		
	BAD DEBTS	VI 24 6,382	
			6,382

GRAND TOTAL COLUMN 3 OTHER 968,879

PLAZA TERRACE
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2005

TOTAL FOOD PURCHASE	149,154	PATIENT MEALS	85488
LESS SALES TAX	(718)	ADD EMPLOYEE MEALS	5475
	-----		-----
NET FOOD	148,436	TOTAL MEALS/YEAR	90963
TOTAL PATIENT CENSUS	28,496	NET FOOD	148436
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	90963

TOTAL PATIENT MEALS	85488	COST PER MEAL	1.63
		TIME EMPLOYEE MEALS	5475
ADD # EMPLOYEE MEALS/DAY	15		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	8924
	-----		=====
TOTAL EMPLOYEE MEALS	5475		

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			36,685	36,685		36,685	28,026	64,711			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			89,534	89,534		89,534	128,159	217,693			32
33	Real Estate Taxes			53,562	53,562		53,562		53,562			33
34	Rent-Facility & Grounds			108,000	108,000		108,000	(108,000)				34
35	Rent-Equipment & Vehicles			17,158	17,158		17,158		17,158			35
36	Other (specify):* amort software			11,107	11,107		11,107		11,107			36
37	TOTAL Ownership			316,046	316,046		316,046	48,185	364,231			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		54,963	244,299	299,262		299,262		299,262			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			50,370	50,370		50,370		50,370			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		54,963	294,669	349,632		349,632		349,632			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,523,250	410,962	1,579,594	3,513,806		3,513,806	2,600	3,516,406			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(10,156)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(718)	2		13
14	Non-Care Related Interest	(8,507)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(5,622)	21		18
19	Entertainment		20		19
20	Contributions		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(6,382)	27		24
25	Fund Raising, Advertising and Promotional	(12,274)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(297)	20		28
29	Other-Attach Schedule	(65,107)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (109,063)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	111,663		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 111,663		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 2,600		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 0	6	1
2	BANK CHARGES	(53,012)	21	2
3	MARKETING SALARY	(8,325)	21	3
4	GARRET BROWN LEGAL FEES	(1,600)	19	4
5	MEYER MAGENCE LEGAL FEES	(500)	19	5
6	RCS MANAGEMENT	(1,670)	19	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(65,107)		49

Summary A

12/31/2005

[illegible]

Summary B

12/31/2005

[illegible]

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	\$ 108,000	3249 W 147TH STREET LTD. PARTNERSHIP		\$	(108,000)	15
16	V	30	DEPRECIATION - BUILDING				38,182	38,182	16
17	V	32	INTEREST - MORTGAGE				136,666	136,666	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 108,000			\$ 174,848	\$ * 66,848	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PLAZA TERRACE # 0040386 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	DONNA ATKIN		ADMIN	30.00				mngmnt fee	\$ 24,000	17-3	1
2											2
3	ELISHA ATKIN		ADMIN.,		LEAF SALARY IS			SALARY	9,304	17-7	3
4			BANK, PURCH		50,224			mngmnt fee	106,778	17-3	4
5	JOEL ATKIN		ADMIN.					mngmnt fee	128,000	17-3	5
6				70.00							6
7	JAY ORLINSKY	CFO	BANKING, A/R		LEAF SALARY IS			SALARY	18,941	17-7	7
8			A/P, ADMIN.		102,250						8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 287,023		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number PLAZA TERRACE # 0040386 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization LEAF MANAGEMENT , INC.
Street Address 9777 N GREENWOOD
City / State / Zip Code NILES
Phone Number (847)470-0000
Fax Number (847)470-0061

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	17	OFFICER SALARY	PATIENT DAYS	154,617	4	\$ 50,224	\$ 50,224	28,642	\$ 9,304	1
2	17	ADMIN SALARY-ORLINSKY	PATIENT DAYS	154,617	4	102,250	102,250	28,642	18,941	2
3	17	ADMIN SALARY-LACEK	PATIENT DAYS	154,617	4	106,250	106,250	28,642	19,682	3
4	19	ACCOUNTING FEES	PATIENT DAYS	154,617	4	9,800		28,642	1,815	4
5	21	OFFICE EXPENSE	PATIENT DAYS	154,617	4	11,333		28,642	2,099	5
6	21	CLERICAL SALARIES	PATIENT DAYS	154,617	4	240,228	240,228	28,642	44,501	6
7	27	PAY.TAXES & HEALTH INS.	PATIENT DAYS	154,617	4	135,588		28,642	25,117	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 655,673	\$ 498,952		\$ 121,459	25

Facility Name & ID Number PLAZA TERRACE # 0040386 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization 3249 W 147TH STREET
Street Address 9777 N GREENWOOD
City / State / Zip Code NILES, IL
Phone Number (847)470-0000
Fax Number (847)470-0061

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION-BUILDING	DIRECT	1	1	\$ 38,182	\$	1	\$ 38,182	1
2	32	INTEREST-MORTGAGE	DIRECT	1	1	136,666		1	136,666	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 174,848	\$		\$ 174,848	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	premier bank(related party)		X	MORTGAGE	\$10,450.00	8/24/04	\$ 1,425,000	\$			0.0625	\$ 77,603	1
2	premier bank(related party)		X	MORTGAGE	\$22,925.00	9/19/05	2,969,414	2,959,702	9/19/08	prime +1		59,063	2
3													3
4													4
5													5
	Working Capital												
6	PREMIER BANK		X	LINE OF CREDIT	\$19,450.00	9/19/05	2,358,452	2,357,505	9/19/08	prime + 1		55,018	6
7	PREMIER BANK		X	LINE OF CREDIT		9/22/3	150,867					26,009	7
8													8
9	TOTAL Facility Related				\$52,825.00		\$ 6,903,733	\$ 5,317,207				\$ 217,693	9
	B. Non-Facility Related*												
10	IRS, IDR, ETC		X	LATE FEES									10
11	DEPT OF PUBLIC AID		X	BED TAX								6,308	11
12	COOK COUNTY TREAS.		X	R.E. TAXES								2,199	12
13													13
14	TOTAL Non-Facility Related						\$	\$				\$ 8,507	14
15	TOTALS (line 9+line14)						\$ 6,903,733	\$ 5,317,207				\$ 226,200	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2004 report.			\$	55,460	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	58,112	2
3. Under or (over) accrual (line 2 minus line 1).			\$	2,652	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	58,112	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	(7,202)	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	53,562	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2000	106,487	8	
		2001	109,176	9	
		2002	53,783	10	
		2003	55,460	11	
		2004	58,112	12	
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL				13	FROM R. E. TAX STATEMENT FOR 2004 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
THE PAYMENT ON LINE 2 APPLIES TO THE 2004 TAX BILL.				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

PLAZA TERRACE

COUNTY

COOK

FACILITY IDPH LICENSE NUMBER

0040386

CONTACT PERSON REGARDING THIS REPORT

BOB KAGDA

TELEPHONE (847) 675-3585

FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A)	(B)	(C)	(D)
				<u>Tax</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
				<u>Nursing Home</u>
1.	28-11-408-003-0000	NURSING HOME	\$ 55,070.10	\$ 55,070.10
2.	28-11-408-004-0000	NURSING HOME	\$ 658.13	\$ 658.13
3.	28-11-408-050-0000	NURSING HOME	\$ 2,383.67	\$ 2,383.67
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 58,111.90	\$ 58,111.90

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: **19,780**

B. General Construction Type: Exterior **BRICK** Frame Number of Stories **1**

C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO

If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	FACILITY		1993	\$ 159,918	1
2					2
3	TOTALS			\$ 159,918	3

Facility Name & ID Number PLAZA TERRACE

0040386

Report Period Beginning:

01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	92		1993		\$ 1,050,000	\$ 38,182	27.5	\$ 38,182	\$	\$ 483,259	4
5	6										5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS		1993		5,150	164	31.5	164		2,081	9
10	VARIOUS		1993		5,006	128	39	128		1,598	10
11	AIR CONDITIONER		1994		19,602	503	39	503		5,805	11
12	ALARM		1994		9,612	246	39	246		2,881	12
13	WALLPAPER		1994		12,345	317	39	317		3,523	13
14	SPRINKLER		1993		3,530		39	91	91	1,001	14
15	IMPROVEMENTS - P.A. AUDIT		1993		13,002		39	333	333	3,663	15
16	CEILING - P.A. AUDIT		1993		13,500		39	346	346	3,806	16
17	NURSES STATION - P.A. AUDIT		1993		1,500		39	38	38	418	17
18	ASBESTOS CONTROL - P.A. AUDIT		1993		1,800		39	46	46	506	18
19	NEW ROOF		1996		26,844	688	39	688		6,565	19
20	NEW WINDOWS		1996		64,075	1,643	39	1,643		15,677	20
21	GENERATOR		1998		57,400	1,472	39	1,472		11,714	21
22	NEW PARKING LOT		1998		37,750	968	39	968		7,058	22
23	NEW GENERATOR		1998		50,100	1,285	39	1,285		8,406	23
24	KITCHEN ADDITION		1999		175,000	4,487	39	4,487		29,353	24
25	FRONT OFFICE REMODELING		1999		17,000	436	39	436		2,852	25
26	CONVERSION OF LAUNDRY TO BATHROOM		1999		12,000	308	39	308		2,015	26
27	HANDRAILS		1999		12,216	313	39	313		2,048	27
28	KITCHEN IMPROVEMENT		1999		39,948	1,024	39	1,024		6,699	28
29	TRANSFORMER		2001		12,100	310	39	310		1,305	29
30	DOOR		2003		5,241	191	27.5	191		485	30
31	HEATING UNIT		2003		10,000	364	27.5	364		925	31
32	ELECTRICAL WORK		2003		3,150	114	27.5	114		290	32
33	DOORS		2004		21,594	785	27.5	785		1,014	33
34	CARPETING		2004		13,324	2,132	5	1,332	(800)	2,664	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,692,789	\$ 56,060		\$ 56,114	\$ 54	\$ 607,611	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 53,815	\$ 5,949	\$ 5,382	\$ (567)		\$ 19,175	71
72	Current Year Purchases	64,292	12,858	3,215	(9,643)		3,215	72
73	Fully Depreciated Assets	44,722					44,722	73
74								74
75	TOTALS	\$ 162,829	\$ 18,807	\$ 8,597	\$ (10,210)		\$ 67,112	75

D. Vehicle Depreciation (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

E. Summary of Care-Related Assets					1	2
		Reference			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$	2,015,536
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	74,867
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	64,711
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	(10,156)
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	674,723

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)				
	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4
86		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		92		\$ 108,000			3
4	Additions							4
5								5
6								6
7	TOTAL		92		\$ 108,000			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES☐ NO
16. Rental Amount for movable equipment: \$ 2,149
- Description: SEE SCHEDULE ATTACHED
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ADMINISTRATOR	05 GMC 3500 VAN	\$ 735.40	\$ 7,354	17
18	ADMINISTRATOR	04 TOYOTA SEQUOIA	850.51	7,655	18
19					19
20					20
21	TOTAL		\$ #####	\$ 15,009	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	\$
13.	/2007	\$
14.	/2008	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

B. EXPENSES

		ALLOCATION OF COSTS		(d)	
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-8	hrs	\$		\$ 105,646	\$		\$ 105,646	1
2	Licensed Speech and Language Development Therapist	39-8	hrs			25,458			25,458	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-8	hrs			112,664			112,664	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-8	# of prescrpts				54,963		54,963	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	39-8				531			531	13
14	TOTAL			\$		\$ 244,299	\$ 54,963		\$ 299,262	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,070,078		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	98,355		6
7	Other Prepaid Expenses	1,824		7
8	Accounts Receivable (owners or related parties)	2,571,929		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,742,186	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	596,133		15
16	Equipment, at Historical Cost	176,153		16
17	Accumulated Depreciation (book methods)	(253,208)		17
18	Deferred Charges	8,840		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(982)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>COMPUTER SOFTWARE</u>	30,375		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 557,311	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,299,497	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 568,869	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,542		28
29	Short-Term Notes Payable	2,357,505		29
30	Accrued Salaries Payable	26,164		30
31	Accrued Taxes Payable (excluding real estate taxes)	26,751		31
32	Accrued Real Estate Taxes(Sch.IX-B)	58,112		32
33	Accrued Interest Payable	6,455		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>DUE TO RELATED PARTY</u>	904,209		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,949,607	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	57,814		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 57,814	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,007,421	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 292,076	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,299,497	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 130,209	1
2	Restatements (describe):		2
3	POST CLOSING ADJ	127,416	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 257,625	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	74,451	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(40,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 34,451	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 292,076	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,539,815	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,539,815	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	48,429	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 48,429	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	13	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 13	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,588,257	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	676,013	31
32	Health Care	1,211,032	32
33	General Administration	961,083	33
	B. Capital Expense		
34	Ownership	316,046	34
	C. Ancillary Expense		
35	Special Cost Centers	299,262	35
36	Provider Participation Fee	50,370	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,513,806	40
41	Income before Income Taxes (line 30 minus line 40)**	74,451	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 74,451	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.
TAX RETURN NOT COMPLETED AT TIME OF FILING COST REPORT

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,055	2,144	\$ 57,463	\$ 26.80	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,941	2,148	48,425	22.54	3
4	Licensed Practical Nurses	15,956	17,001	356,675	20.98	4
5	CNAs & Orderlies	55,984	59,176	516,237	8.72	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,394	1,458	29,154	20.00	8
9	Activity Director	498	506	9,366	18.51	9
10	Activity Assistants	4,548	4,908	45,174	9.20	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	407	407	7,584	18.63	13
14	Head Cook	8,578	9,503	103,049	10.84	14
15	Cook Helpers/Assistants	6,942	7,126	51,388	7.21	15
16	Dishwashers					16
17	Maintenance Workers	3,204	3,320	46,108	13.89	17
18	Housekeepers	8,219	8,873	76,503	8.62	18
19	Laundry	5,516	5,597	40,245	7.19	19
20	Administrator	1,390	1,492	44,276	29.68	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,061	3,157	37,841	11.99	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,244	2,364	45,437	19.22	31
32	Other Health Care(specify)					32
33	Other(specify) <u>MARKETING</u>	256	393	8,325	21.18	33
34	TOTAL (lines 1 - 33)	122,193	129,573	\$ 1,523,250 *	\$ 11.76	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 0	1-3	35
36	Medical Director		0	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	MONTHLY	1,595	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant		0	11-3	44
45	Social Service Consultant		0	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 1,595		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		\$		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

STATE OF ILLINOIS

Facility Name & ID Number

PLAZA TERRACE

0040386

Report Period Beginning: 01/01/2005

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Ending: 12/31/2005

A. Administrative Salaries

Name

Function

Ownership

Amount

LATONYA DAVIS

ADMIN

\$ 44,276

ASST ADMIN

0

TOTAL (agree to Schedule V, line 17, col. 1)

(List each licensed administrator separately.)

\$ 44,276

B. Administrative - Other

Description

Amount

ELISHA ATKIN

\$ 106,778

DONNA ATKIN

24,000

JOEL ATKIN

128,000

TOTAL (agree to Schedule V, line 17, col. 3)

(Attach a copy of any management service agreement)

\$ 258,778

C. Professional Services

Vendor/Payee

Type

Amount

\$

SEE SCHEDULE ATTACHED

67,497

TOTAL (agree to Schedule V, line 19, column 3)

(If total legal fees exceed \$2500 attach copy of invoices.)

\$ 67,497

D. Employee Benefits and Payroll Taxes

Description

Amount

Workers' Compensation Insurance

\$ 38,918

Unemployment Compensation Insurance

45,995

FICA Taxes

116,234

Employee Health Insurance

34,444

Employee Meals

8,924

Illinois Municipal Retirement Fund (IMRF)*

EMPLOYEE BENEFITS - OTHER

14,678

EMPLOYEE PHYSICAL EXAMS

0

PENSION/PROFIT SHARING PLANS

0

CHICAGO HEAD TAX

0

INSURANCE - EXECUTIVE LIFE

0

INSURANCE - EXECUTIVE LIFE VI 21

0

TOTAL (agree to Schedule V, line 22, col.8)

\$ 259,193

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description

Line #

Amount

\$

TOTAL

\$

F. Dues, Fees, Subscriptions and Promotions

Description

Amount

IDPH License Fee

\$ 1,990

Advertising: Employee Recruitment

0

Health Care Worker Background Check

1,976

(Indicate # of checks performed)

MARKETING/ADV/PROMO

12,571

TRUST/FRANCHISE/CONTRIB/ETC

0

LICENSES & PERMITS

(1,049)

DUES & SUBSCRIPTIONS

1,729

MGMT CO ALLOCATION

TRUST/FRANCHISE/CONTRIB/ETC

0

Less: Public Relations Expense

(0)

Non-allowable advertising

(12,274)

Yellow page advertising

(297)

TOTAL (agree to Sch. V, line 20, col. 8)

\$ 4,646

G. Schedule of Travel and Seminar**

Description

Amount

Out-of-State Travel

\$

In-State Travel

0

Seminar Expense

0

Entertainment Expense

()

(agree to Sch. V, line 24, col. 8)

TOTAL

\$

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL. ASSOC. OF HEALTHCARE \$1729
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 50,370
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 8,924 Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees